



LOUISIANA DEPARTMENT OF INSURANCE
Office of Health Insurance
P. O. Box 94214 - 950 North Fifth Street, 70802
Baton Rouge, LA 70804
(800) 259-5300 (225) 219-4770 Fax (225) 342-5711

PROVIDER PROMPT PAYMENT COMPLAINT FORM

Part I

SECTION 1

SECTION 2

SECTION 3

Provider Information			
Name of Provider			
Address			
City	State	Zip Code	
Contact Person			
Telephone Number		E-mail Address	
Complete Appropriate Block as it Applies		✓ Appropriate Box as it applies to claim submission	
Contracted Provider Number:		<input type="checkbox"/> Electronic Claim:	
Clearinghouse Name if applicable		<input type="checkbox"/> Non-Electronic Claim	
Complaint Against			
Company Name			
Address			
City	State	Zip Code	

PROVIDER PROMPT PAYMENT COMPLAINT FORM

Part II

CHECK ONE BOX ONLY

- ☐ Claims are not paid timely
- ☐ Claims not received then denied for non-timely filing
- ☐ Claims rejected then denied for non-timely filing
- ☐ Unreasonable requests for medical information
- ☐ Unreasonable COB inquiry-No other insurance
- ☐ Denial for lack of authorization when authorized
- ☐ Audit of claim after allowed period
- ☐ Recoupment of payment without notice
- ☐ Other – NON-Contractual (Explain below)